CareSource PASSE

Statement of Medical Necessity Information Form
for INGREZZA® (valbenazine) or AUSTEDO® (deutetrabenazine)

Fax completed form to **1-866-930-0019** ☐ **Standard** ☐ **Urgent**

*****Incomplete or illegible information may delay processing*****

BENEFICIARY INFORMATION (one form per request) **Request Date:** _____

Beneficiary First Name: _____ Beneficiary Last Name: _____

Medicaid ID: _____ Beneficiary's Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

PRESCRIBER INFORMATION

Prescriber First Name: _____ Prescriber Last Name: _____

Prescriber National Provider Identifier (NPI): _____ Specialty: _____

Drug Enforcement Administration (DEA) Number: _____ Prescriber Medicaid ID: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Contact Person (if additional info needed): _____

Preferred Contact Method (include method and contact information): _____

DRUG INFORMATION ☐ Initial Request ☐ Renewal Request

Drug Name: _____ Drug Strength: _____

Drug Form: _____ Quantity: _____

Dosing: _____

Diagnosis: _____ Diagnosis Code: _____

Patient's Full Name: _____

CRITERIA (Complete all questions. Chart notes to support answers are required)

1. List any oral, facial and lingual dyskinesia symptoms observed:

   _____

   _____

2. List any dyskinesia symptoms of the limbs observed:

   _____

   _____

3. List any dyskinesia symptoms of the neck and trunk observed:

   _____

   _____

4. Do any of the dyskinesia symptoms observed interfere with activities or functions of daily living? If so, list all that apply and describe interference:

   _____

   _____

   _____

5. List all known past dopamine receptor blocking agents (e.g., antipsychotic agents or metoclopramide) and length of therapy of each:

   _____

   _____

6. List any recent changes to antipsychotic drug therapy the patient is receiving:

   _____

   _____

7. List all current medications and their dosage:

   _____

   _____

☐ Attachments

Prescriber's Signature: _____ Date: _____

(Prescriber's original signature required; copied, stamped, or e-signature are not allowed.)

This signature certifies that the information provided in the Statement of Medical Necessity is accurate and substantiated by the patient's medical records**.**